Art. XXIV.—*Saint Thomas's Hospital Reports.* New Series. Edited by Dr. Bristowe, Dr. Stone, and Mr. Croft. Vol. ii., 8vo., pp. x., 381. London: J. & A. Churchill, 1871.

We shall first invite attention to the medical papers in this volume. These are rather more numerous than the surgical, and some of them are scarcely of as practical a character as is desirable in a volume of Hospital Reports. We are glad to see, however, that the editors are determined that the series, of which this volume is a part, shall not only be continuous but valuable, for even those papers to which we have alluded as not of a practical character show great care in their preparation. Dr. Peacock's communication is of course valuable, and to Dr. Evans belongs the merit of having contributed a paper which not only gives us a good deal of information, but will do much towards causing the recognition of the fact that thoracentesis is not merely a justifiable operation, but one which in many cases a due sense of his obligation to his patient will compel a conscientious physician to perform.

Art. I. *An account of some Experiments relating to the Influence Exercised by Colloids upon the Forms of Inorganic Matter.* By William M. Ord, M.B., London.—Mr. Ord contributed a paper to the first volume of these Reports, entitled "Some experiments relating to the forms assumed by uric acid," which was noticed in the April number of this Journal for 1871, and in which he showed very clearly that the crystalline forms assumed by uric acid in the urine have a definite relation to the composition of that fluid. In the present communication he demonstrates equally clearly that colloids have a decided influence in controlling crystallizing force, and that albumen is much more active, in this respect, than gelatine. The paper will be found of interest to those who are especially engaged in this kind of investigation, but does not very readily admit of analysis.

Art. II. *On the Period of Incubation of Typhus, Relapsing Fever, and Enteric Fever.* By Charles Murchison, M.D., Edin., F.R.S.—Dr. Murchison tells us that throughout the period of his active connection with the London Fever Hospital, he was on the constant lookout for cases calculated to throw light upon the subject of this memoir, and that in it he has placed on record all such cases he encountered among upwards of ten thousand patients suffering from the continued fevers, who have been under his immediate care. The paper is a long one, and we shall, therefore, give only his conclusions, which are as follows: "The period of incubation of typhus varies in duration in different cases. In a large proportion of cases it is about twelve days. In exceptional cases it is longer than twelve days, but it rarely, if ever, exceeds three weeks. In many cases (one third or more) it is less than twelve days, and occasionally there is scarcely any latent period, the symptoms commencing almost at the instant of exposure to the poison.

"The period of incubation of relapsing fever is not a fixed period, and is even more variable than that of typhus. It is, on the whole, shorter than that of typhus. Occasionally, as in typhus, there is scarcely any latent period at all, the symptoms commencing almost immediately after the first exposure to the poison.

"The period of incubation of enteric fever is most commonly about two weeks. Instances of a longer duration appear to be more common than in typhus or relapsing fever. The period of incubation is often less than two weeks, and, as in typhus and relapsing fever, it may not exceed one or two days."

Art. IV. *On the Existence of Continued Currents in Fluids.* By GEORGE RAINEY, M.R.C.S.—This communication is a sequel to the paper on the same subject in the first volume of these reports, which was briefly noticed in the April number of this Journal for 1871. Mr. Rainey has been able to simplify the apparatus by which the earlier experiments were performed. The conclusions at which he arrives are very similar to those reached in the former paper, and are as follows: 1st. That the particles of all fluids, irrespective of quantity or form, are always in motion; 2d, that this motion is produced by the combined operation of two forms of attraction, namely, that acting at apparent contact, and that acting at all sensible distances; 3d, that the movements of the particles in these distances, though modified by temperature, are not caused by it; 4th, that the rate of movement of these particles, besides being affected by certain physical properties of the fluid, such as that of density, of tenacity, etc., is influenced also by the form in which they are aggregated; as for instance, if the form be that of a sphere, all the particles, being directed towards one centre, will move more rapidly than if the same particles are extended over a larger space, and consequently be directed to several centres at the same time.

Art. V. *On Paracentesis Thoracis.* A Thesis read for the Degree of M. D. Cantab. By G. H. EVANS, M.D., M.R.C.P.—After giving a very full *résumé* of the history of this operation, Dr. Evans proceeds to state his reasons for believing it to be expedient to remove the fluid from the chest as early as possible in cases of pleuritic effusion, and for thinking that paracentesis thoracis is the best and safest way of accomplishing this. In the first place, pleuritic effusion may of itself cause fatal results, which could have been prevented by the early abstraction of the fluid, and to show this he reports a case in which the sudden death of the patient could be attributed to no other cause, and refers to numerous cases of a similar character recorded by Trousseau, Cruveilhier, Chomel, Aran, and others. Secondly. The long continued compression of one lung by pleuritic effusion predisposes to acute and chronic diseases, tubercular or otherwise, of the lung of the other side, simply because an overworked lung, like an overworked man, is placed in an unfavorable condition for resisting noxious influences to which it may be exposed. Of course, with one lung useless, the patient's chances of recovery are slight when diseases attack the other. Thirdly. The lung which has been long compressed by pleuritic effusion is rendered thereby incapable of re-expanding, not only in consequence of the formation of firm adhesions between the pulmonary and costal layers of pleura, and the thickening of the pulmonary pleura by the deposition of lymph, but also, Dr. Evans believes, because of the tendency to the stagnation and subsequent coagulation of the blood in the pulmonary artery which exists in cases of compression of the lung by pleuritic effusion.

The objections which have been made to the operation of paracentesis thoracis may be stated to be as follows: (*a*) the danger of death from syncope during or immediately after the operation; (*b*) the operation itself setting up suppurative inflammation; (*c*) the probability of the admission of air, and consequent suppurative inflammation; (*d*) the possibility of hemorrhage from the operation. In regard to the first objection, the author shows that out of a total number of 820 cases, in only two is it recorded that death was in any way the result of the operation; in one of these death was caused by hemorrhage from wounding small arteries by the puncture; in the other, it took place the next day, and was attributed to the shock of the operation. In none is there any mention made of the fatal syncope which has been supposed to be likely to ensue upon the sudden removal of a large pleuritic effusion. The belief that the operation itself has a tendency to cause fresh inflammation, especially if air be admitted, seems also to have very little foundation in fact. He does not himself believe that the admission of air into the pleural cavity is followed by an aggravation of the symptoms; but, even if it were, he sees no force in the objection, since the operation may be performed in such a way as effectually to exclude air. In twenty-eight cases, which he tabulated, the operation was performed more than once; in twenty-four of these the fluid drawn off was serum each time; in the remaining four cases it was purulent in one or more of the subsequent tappings. The probability of hemorrhage from the operation, alluded to by Dr. Addison, is best combated by a reference to the case mentioned above, as being the only one in 820 in which it occurred, and then it was said to be due to an abnormal arrangement of small anastomosing vessels.

In addition to relieving the patient at once of distress and dyspnœa, and freeing him from the danger of sudden death, the operation places him at once in a more favourable condition for the absorption of the remaining fluid, which is very well shown in one of the cases reported by the author. In this case the patient passed two gallons of urine during the twenty-four hours immediately succeeding the operation.

The tables which accompany the paper show very clearly the advantage of performing the operation early in the disease. Thus, out of a total of 533 cases, 373 recovered, 153 died, and in 7 the result is doubtful; this makes the rate of mortality 29 per cent. But out of a total of 308 cases, in which the effused fluid was serum, 74 died, making the rate of mortality 24 to 26 per cent. In 24 cases of serous effusion, in which the operation was performed not later than the end of the fourth week, 21 recovered and 3 died; in one of the three fatal cases there was disease of the liver, and in the other two the operation was performed as a last resource, merely with the view of prolonging life. In 17 cases where the operation was performed after the first month, but not after the second, 13 recovered and 4 died; one of these latter died two years afterwards from phthisis. In 10 cases where it was after the second month but not after the fourth, 5 recovered and 5 died. In 8 cases, where the effusion was of more than four months' duration, 3 recovered and 5 died.

Dr. Evans prefers to operate according to the plan proposed by Reybarb and adopted by Trousseau, which consists in tying a flap of moistened goldbeater's skin round the mouth of the canula so as to form a valve or curtain which admits of the air passing freely out, but prevents it from making its way in.

Art. VII. *On the Action and Use of the Opium Alkaloids, Cryptopia and Thebaia.* By John Harley, M.D., London.—Dr. Harley has already published some observations on the physiological action of cryptopia, but, having been enabled, by the kindness of the discoverers of the alkaloids, to prosecute his inquiries further, he gives us in this paper the results of his experiments with it on the dog, the cat, the rabbit, and on man. He believes that cryptopia, in its effects on the nervous system, stands exactly midway between morphia and thebaia, sharing equally in the qualities of both. "We have," he says, "applied the test of different nervous systems to the substance, and found that those of the mouse, of some dogs, and of man, give sleep, while those of other dogs, of the cat, and of the rabbit, give convulsion. A grand physiological truth lies here, for surely these experiments teach us that sleep and convulsion are but one, mutually and readily interchangeable, the variation being determined by certain peculiarities resulting from mechanical or molecular variations of the nervous system; in a word, the one test gives us white light, the other a coloured spectrum."

In regard to the excitant action of cryptopia as compared with that of thebaia, he says the broad distinction between the two alkaloids is this, that the convulsion of thebaia is a *persistent* spasm, and that of cryptopia an *intermittent* one. Thebaia holds the muscles with the most inflexible vigour, and the stiffened and motionless body may be held straight out by one of the extended hind legs. Cryptopia throws the whole of the voluntary muscular system into rapid and violent vibration. In regard to the difference between the hypnotic and general effects of morphia and cryptopia, the author says the sleep of cryptopia is as prolonged as that of morphia, but it is lighter and consequently more refreshing, and quite free from the illusions which so often attend sleep induced by morphia. But this is not the only advantage which cryptopia possesses over morphia. Cryptopia exercises no deranging influence over the vagus, and its administration either by the stomach or subcutaneously never gives rise to vomiting or to faintness. As an hypnotic it is about one-fourth as powerful as morphia. It is not eliminated to any great extent by the kidneys.

Dr. Harley has found that the hypnotic action of thebaia on man is, as far as has been observed, free from all unpleasant effects. As a soporific, 1½ grains are about equal to one-fourth of a grain of a salt of morphia. The contracting effect on the pupil is, in most cases, much weaker than that of morphia, but it possesses an equally stimulating effect upon the pulse. He has also found that atropia increases and prolongs the hypnotic action of thebaia.

Art. IX. *Remarks on the Healthy and Morbid Anatomy of the Perivascular System of the Brain.* By W. W. WAGSTAFFE, F.R.C.S.—After alluding to the history of the discovery of the perivascular system of the brain, Mr. Wagstaffe narrates three cases illustrative of its morbid anatomy. In the first case, tubercular deposits were found scattered freely over the surface of the brain, but the tubercle was always definitely related to the vessels. At the upper surface of the hemispheres, clusters of miliary deposits were arranged along the sides of the larger vessels; in some cases the naked eye could trace small vessels running into single deposits: in a large mass in the Sylvian fissure, the carotid and the middle cerebral arteries were surrounded by the new growth. When a portion of the pia mater was examined microscopically, the relationship of the deposits to the vessels was still more clearly seen; the first thing which attracted attention being the marked distension of the perivascular canals. These, which are often difficult to demonstrate in the meninges in health, were now very distinct, and distinct from being distended with abnormal contents. They contained corpuscles exactly similar to those found in the masses of tubercles. But, besides the diffusion of the elements of tubercles in these perivascular canals, and their great abundance near the masses of the deposit, further evidence was obtained of the relation between them. One of the very small miliary deposits was examined, and found to be situated entirely within the perivascular sheath. The corpuscular bodies which are found within these perivascular sheaths are regarded as lymph-corpuscles, and there is, therefore, every reason to believe that miliary tubercles consist of aggregations of lymph-corpuscles, and in this connection Mr. Wagstaffe says; "I am inclined, then, to trace the source of these tubercle corpuscles to the cells occupying the sheath normally as an epithelium which is intermediate between the spheroidal and tesselated varieties, and would look upon the disease as one of excessive multiplication. Although the elements of ordinary inflammation consist in the main of cells whose appearance is identical with these lymph-elements, we are not justified, I think, in looking upon the tuberculous disease as simple inflammation, or as His suggests, inflammation of the perivascular sheath, for we do not find an alteration in the fibrous part of the sheath wall, or the presence of fibre-cells, until later in the disease, when the primary deposit has probably acted as a focus of inflammation. Moreover, the peculiarity of the miliary character of the deposits distinguishes tuberculous from ordinary inflammation."

Art. XI. *Cases of Stricture of the Œsophagus.* By E. Clapton, M.D., F.R.C.P.—Two cases of stricture of the œsophagus are reported in this paper. In the first case death was probably due to hemorrhage from the left common carotid artery, the cancerous ulceration which originally affected the œsophagus and produced the symptoms of stricture having finally caused a perforation of the artery. In the second case, from the great relief afforded by the passing of bougies, Dr. Clapton was inclined to believe that there existed simply a fibrous thickening at the lower portion of the œsophageal tube.

Art. XII *On Ægophony.* By Wm. H. Stone, F.R.C.P.—From experiments which are detailed in this communication, Mr. Stone was led to the following conclusions in regard to the *modus operandi* of ægophony. The layer of fluid in pleurisy stops the larger and coarser vibrations of the ground-tone, but allows the fine and close undulations of the high harmonics to pass. "We thus," he says, "have phenomena in what we may call an ascending scale; beginning with the rough vibration of vocal fremitus, which, like some forms of loud cardiac murmur, is actually sensible to the tactile papillæ of the finger, but which is easily intercepted, through the phenomena of vocal resonance which are more penetrating, up to ægophony, which is thus explained to be vocal resonance divested of its lower fundamental tones by the deadening effect of a layer of more or less inelastic fluid. Therefore, I was led early in the paper to name it a filtration. It is thus not dissimilar in kind from that which, in a transparent medium, like glass, obstructs the undulations of sound and heat, but gives free passage to the finer and more subtle pulsations of light."

Art. XIV. *On Impairment or Loss of Power of Articulate Speech.* By John S. Bristowe, M.D., F.R.C.P.—This paper, although well written, and containing the reports of many interesting cases of the various conditions comprised under the term aphasia, does not advance any facts which have not already been considered in former numbers of this Journal, except perhaps the one that Dr. Bristowe is inclined to look upon agraphia as an amnesic rather than an ataxic defect. "The patient," he says, "cannot speak because he has forgotten words, he cannot read, because he has forgotten the precise meaning of letters and their combinations, and he cannot write because he cannot recall to his mind the complex combinations of strokes which represent words."

Art. XV. *On the Prognosis of Valvular Diseases of the Heart.* By Thomas B. Peacock, M.D., F.R.C.P.—Dr. Peacock shows very clearly in this paper that there are other elements which must be taken into consideration, in making a prognosis in valvular diseases of the heart, than the amount of lesion of the valves themselves. The principal sources of danger in this class of affections are three. 1, failure of the muscular power of the heart; 2, congestion of the organs anterior to the seat of obstruction; 3, thrombosis and embolism. These are more prone to occur in some forms of valvular diseases than in others, and they may be variously combined and may ensue at different times in the course of the same case. The following passage will give the results of his experience in a few words: "In reviewing what has been said as to the sources of danger in different forms of valvular disease, it will be seen that incompetency of the valves is regarded as a more serious defect than obstruction; and of the affections of the valves of the left side of the heart, I conceive incompetency of the aortic to be more dangerous than the similar condition of the mitral valves. Not only does incompetency of the aortic valves occasion great impediment to the circulation, and especially cause an imperfect supply of blood to the brain; but as the power of the left ventricle becomes rapidly exhausted, there is danger at any moment of death by syncope. In the corresponding condition of the mitral valves, though it seriously obstructs the pulmonic circulation and occasions great visceral congestion, death is brought about more slowly as the result of the imperfect aeration of the blood and its impure condition from the state of the parenchymatous viscera, and by dropsical effusions, as sudden death is less likely to occur. As regards obstructive disease of the two sets of valves, I should reverse the order in which they are regarded as serious, obstructive disease of the mitral being apparently a more important defect than the same affection of the aortic valves. In the former condition the combined power of the left auricle and right ventricle is unable adequately to propel the blood through the left auriculo-ventricular aperture, and hence the lungs and other organs soon become very greatly engorged; while in cases of aortic constriction the left ventricle long resists the impediment, and it is only when the obstruction has become extreme, and the power of the ventricle is impaired, that the more distant organs are involved."

Conditions, other than those already mentioned, which are not without influence on the duration of the patient's life are, 1, the number of valves diseased; 2, the nature of the complications, and 3, the circumstances of the individual.

Dr. Peacock also calls attention to the fact that the intensity of the murmur is by no means the measure of the amount of disease. "For the production of a murmur," he says, "two elements are necessary; there must be a source of obstruction to the circulation, and the blood must be propelled with power through such impediment." Hence, for instance, in cases of general bronchitis accompanied by great embarrassment of the circulation, the heart action may be so feeble as not to give rise to a murmur, which, however, will be distinctly heard when under the influence of rest, a genial temperature, and suitable treatment, the bronchitic symptoms have subsided and the action of the heart has become stronger and more regular.

Art. XVIII. *On Hypertrophic Polypus of the Os Uteri, and its relation to Hypertrophy of the Cervix Uteri.* By ROBERT BARNES, M.D.—Dr. Barnes, after speaking of the fact of the frequent coincidence of small polypi springing from the edge of the os uteri, with hypertrophy and prolapsus of the cervix uteri, which has led to the conjecture either that a common cause produces both, or that one entails the other, says that the truth appears to be that the excessive growth which results in hypertrophy, sometimes also produces polypi as well. The pathological history of "hypertrophic polypi" may be told as follows: The first condition of their existence is hypertrophy of the cervix uteri. Frequently the os uteri being lobulated or fissured, as is also seen after labour, one lobe or portion of a lip may take on an exaggerated growth, and project beyond the level of the os. "In such a case," he says, "if studied by the light of observation of more advanced or completed polypoid formation, we may see the origin of the hypertrophic polypus. A small lobe, more or less marked out on the os by a fissure or depression on either side, continues to grow under the same stimulus that determines the general hypertrophy of the cervix. It grows a little more quickly; then its base, being compressed by the firm structure of the os on either side of it, is squeezed and elongated until it assumes the characteristic polypoid shape."

In regard to the treatment of these polypi, he says they should be removed with the scissors. The bleeding which is apt to follow this operation should be checked by hemostatics, the precaution being taken to keep the patient in bed for two or three days afterwards, if there is much hypertrophic extension of the cervix uteri. After the inflammation excited by the operation has subsided, a free slough of the most hypertrophic lip should be wrought by applying potassa cum calce, or the actual cautery in a line across the lip. The healing of this slough induces altered nutrition of the part, promotes absorption, and the contraction following, being inwards, or centripetal, acts in direct antagonism to the morbid hypertrophic extension.

Report of the Obstetrical Department. By Henry Gervis, M.D., London.—From this report it appears that 1250 children were born in the obstetrical wards of St. Thomas's Hospital between December 6, 1869, and December 6, 1870. Of this number 1206 were born alive, and 44 were stillborn, or 3.5 per cent. Eighteen women were delivered of twins. Of the 1232 cases attended, 150 were first labours; 169, second; 170, third; 176, fourth; 149, fifth; 110, sixth; 102, seventh; 67, eighth; 58, ninth; 32, tenth; 14, eleventh; 13, twelfth; 10, thirteenth; 2, fourteenth, and 1 was a seventeenth labour. Of the 1250 children born, the following specifies the presentation: vertex, 1212; breech, 23; footling, 5; arm, 2; face, 5; brow, 3.

The usual table of diseases treated at the hospital, during the year, is appended to the volume. J. H. H.

We shall now invite our readers' attention to those papers which are particularly interesting to surgeons, and in the first place to

Art. III. *Some Remarks on Gunshot Wounds of the Lower Extremity.* By William Mac Cormac, F.R.C.S.—Mr. Mac Cormac's name is already familiar to the readers of this Journal through bibliographical notices of several surgical pamphlets, which he published while connected with the General Hospital at Belfast, and more recently through notices of his well-known volume, "Notes and Recollections of an Ambulance Surgeon," which was founded on the author's large experience during the recent Franco-Prussian war. The present paper is characterized by the same philosophic and eminently practical tone which marked Mr. Mac Cormac's previous writings, and may be studied with advantage by both civil and military surgeons. With regard to the treatment of gunshot fractures of the femur, the author says:—

"The first examination should be the only one, and must determine whether an attempt shall be make to preserve the extremity. After that, the less handling or interference of any kind the better. Stromeyer urges that our first care should be to endeavour to save the life of the patient with fracture of the thigh, and afterwards, if possible, to rectify the deformity. . . . There can be little doubt, that violent continuous extension of a bullet-smashed femur, combined with frequent handling and re-adjustment, must prove injurious in the extreme. Stromeyer has almost completely abandoned forcible extension and counter-extension, and prefers simply to lay the limb on the side, in the position advocated by Pott. In my own practice I employed long splints sometimes, sometimes sand bags, with a small weight merely to steady the limb attached to the foot. In two instances that I know of, subsequent deformity was successfully relieved by refracturing the bone. . . . When amputation is considered necessary in these cases, let it be done at once, during the first twenty-four hours. . . . A very interesting question is raised by Stromeyer in respect of amputations, namely, that we need not amputate clear of the diseased or injured soft tissues in ordinary cases, but may divide the bone, unless split up and inflamed, just at the seat of fracture. The track of a ball or a sinus may safely be left in the flap, and the high division of the bone, which so largely increases the risk, is thus obviated. . . . The considerations detailed in this paper appear to me to afford ground for concluding against the universal application of amputation in regard of gunshot fractures of the shaft of the femur. Sound, though it may be delayed, union will often follow conservative treatment. I think for general guidance we may for the present declare that, in fractures of the lower half of the femur, the rule should be when in doubt to amputate, while in those of the upper half of the bone the converse should apply, namely, when in doubt to try to preserve the limb."

Mr. Mac Cormac's paper is illustrated with two plates, which appear to have been executed by what is known as the "heliotype" process.

Art. VI. *On the Therapeutical Importance of Recent Views of the Nature and Structure of Cancer.* By HENRY ARNOTT, F.R.C.S.—This paper is one of great interest and value, and its conclusions carry with them a great deal of authority, on account of the author's large practical experience in the cancer wards of the Middlesex Hospital. Referring to the diversity of opinion which prevails among medical men as to the advantages to be derived from operations in cases of cancer, Mr. Arnott remarks, "that the majority of operating surgeons are strongly in favour of the knife, whilst the majority of physicians and surgeons, little used to operations, declaim against this remedy." The fact is we believe correctly stated, but we are loth to accept Mr. Arnott's explanation, that "personal prejudice" influences either party's judgment in the matter; we believe the true explanation is to be found in the different nature of the operator's and of the non-operating medical man's experience; the former has often the opportunity of seeing the advantages derived from early interference, while the latter, regarding an operation as a forlorn hope not to be resorted to as long as it can be avoided, necessarily sees the operation performed under less favourable circumstances, and forms a less favourable opinion of the benefits which it is capable of conferring. In discussing the oft-mooted question of the local or constitutional origin of cancer, Mr. Arnott considers with great fairness the various facts and arguments which have been advanced on either side, and states his conclusions in the following language:—

"A calm survey of the two opposite views of the nature of cancer, and of the facts which are adduced in support of them, seems to leave us in about this position: that, while it is impossible absolutely to deny the existence of a special dyscrasia as the cause of the appearance of malignant tumours, the evidence in its favour will not bear careful scrutiny, although it may be admitted that certain individuals and even families exhibit a remarkable predisposition to the occurrence of these growths, just as a similar predisposition may be shown to the appearance of fatty growths, warts, or other such local defects of nutrition; that owing to appreciable physical causes—as the special arrangement of structural elements, the part of the body attacked, etc.—certain tumours are more prone to malignancy than others; that whether the original growth be absolutely local or depending on general changes in the system, a stage may be at length reached in which there may be, indeed, an ineradicable and necessarily fatal blood contamination; and, finally, that as all the real evidence before us goes to prove that it is in any case the *local tumours or ulcers which kill*—either by invasion of vital organs, or by the breaking up of health caused by excessive hemorrhages, pain, and exhausting and fetid discharge from the primary seat of the disease—these should be completely removed when possible."

Art. VIII. *Description of a Case of Unreduced Dislocation of the left Femur, in which Death occurred Eight Days after the Receipt of the Injury.* By WILLIAM MAC CORMAC, F.R.C.S.—It is so seldom that the surgeon has an opportunity of dissecting the parts concerned in an unreduced recent dislocation of the hip, that Mr. Mac Cormac's description of the appearances observed in the instance here narrated is of much interest. The dislocation in the case given was backwards, the head of the bone (as shown by a well executed wood-cut) lying just behind the acetabulum, with the pyriformis and gluteus minimus muscles above, and the obturator internus and torn gemellus muscles immediately below. After quoting the views of our distinguished fellow-countryman, Prof. Bigelow, as to the mechanism of hip dislocations, Mr. Mac Cormac adds:—

> "A careful examination of my own specimen confirms in a remarkable manner most of these statements. After dissection the deformity was persistent and identical with that existing during life. The dislocating force had been applied when the thigh was flexed at right angles, and the bone was driven directly backward between the pyriformis and obturator internus muscles. The locking or rigid condition of the limb was very evident, while the rent in the capsule was limited to its posterior part. Manipulation after the manner described by Bigelow appeared in the dissected specimen to be the way in which the head of the bone might most readily be returned to the socket."

Art. X. *Remarks on the Theory and Practice of Epidermic Grafting.* By WILLIAM ANDERSON, F.R.C.S.—In this paper Mr. Anderson, who is the Surgical Registrar of St. Thomas's Hospital, gives an interesting account of the experience at that institution of M. Reverdin's method. In the following sentences, the writer, it seems to us, estimates very justly the advantages and disadvantages of the new process as compared with ordinary plastic operations; in the latter,

> "we cover in a freshly exposed surface with a portion of integument in its entire thickness, usually commensurate in size with the area prepared for its reception, and retaining a connection with adjacent parts by means of a vascular isthmus. Such a covering possesses, of course, all the natural advantages with the minute structure of true skin, but the material employed for filling up the one gap has been gained by making another. . . . On the other hand, epidermic grafting, after the manner of M. Reverdin, has the recommendation that the amount of tissue required for the process is small, the operation simple and without risk, and, more particularly, that a failure is in no degree serious; but it must be borne in mind that the best result attainable is the production of a sound cicatrix, often, it is true, stronger and more pliant than the ordinary cicatrix of a large slowly healing sore, but still possessing the main imperfections of such a texture."

Art. XIII. *Cases of Inversion of the Bladder.* By JOHN CROFT, F.R.C.S.—The great rarity of the occurrence of inversion of the bladder may be inferred from the fact that Mr. Croft's case is but the fourth which has been recorded. The affection is exclusively met with in female infants, and Mr. Croft's patient (aged 14 months), was the youngest of the four whose histories have been published. This case is also remarkable on account of the occurrence of rupture of the inverted viscus (as shown by the escape of a clear, straw-coloured, *non-urinous fluid*), an accident which did not, however, entail any unfavourable consequences after the reduction of the protruded organ. In order to add to the interest of his paper, which is one of great value, Mr. Croft annexes abstracts of the three cases previously observed by Dr. Murphy, Mr. Crosse, and Dr. Lowe respectively.

Art. XVI. *On a New Method for Extraction of Cataract.* By R. LIEBREICH, M.R.C.S.—This paper contains the best account which we have as yet seen of Mr. Liebreich's new operation, of which we shall now endeavour to give our readers a description, using, as far as possible, the author's own words. The distinctive peculiarities of Mr. Liebreich's method are, that the section is made in a downward direction, and lies entirely (except the points of puncture and counter-puncture) within the cornea, and that there is no iridectomy. The instruments employed are a very small Graefe's knife, a cystotome, and a common Daviel's spoon, all of which may be combined in a single handle. The patient is placed on his back, the pupil having been previously dilated with atropia, and chloroform may be administered if necessary; the surgeon stands behind the patient's head to operate on the right eye, and at his left side to operate on the left eye.

"Supposing the right eye is to be operated upon. In that case the operator takes hold of the upper eyelid with the index finger of his left hand, whilst he slightly presses the middle finger against the inner canthus of the eye. The knife held in the right hand with its back horizontal and backwards, the plane of the blade making with the horizontal meridian of the eye an angle of about 45°, enters the sclerotic with its point about one millimetre externally to the margin of the cornea. . . . *Without altering the direction*, the knife passes through the anterior chamber in order to make the contra-puncture on the opposite side, so that the point of the knife becomes visible in the sclerotic, about one millimetre (or less) distant from the cornea. The knife is now pushed forwards, so that its retraction finishes the incision. As soon as the incision is made, the eyelid is to be dropped.

"The second part of the operation consists in the careful opening of the capsule.

"In the third part, Daviel's spoon is slightly pressed against the inferior margin of the cornea, and the index finger of the left hand, which holds the upper eyelid, through it exerts a very slight pressure on the highest point of the cornea. Thus the lens is made to rotate a little, its lower margin presses in the manner already described against the posterior surface of the iris, pushes the iris forward, passes along it to the margin of the pupil, overcomes the obstacle and places itself freely in the wound, which is made to gape by Daviel's spoon pressing against it. A slight pressing movement of the index finger of the left hand, by means of which the upper eyelid is shifted from above downwards over the cornea, serves to expel the lens. Similar movements of the lids are employed for the purpose of forcing out any *débris* of the cortical substance, after pushing them from behind the iris towards the pupil, by gently rubbing the shut eyelids. Should the pupil then not appear round, but its margin drawn towards the wound, it regains its normal position by an outward shifting of the lower lid; or, if that be not sufficient, by the introduction of Daviel's spoon."

The after-treatment consists in the instillation of atropia, and the application of a compressing bandage.

Art. XVII. *On Cleft Palate.* By FRANCIS MASON, F.R.C.S.—Mr. Mason, in this short but practical paper, refers to the well-known fact that in many cases, though staphyloraphy may succeed as an operation, it yet fails in obtaining the desired improvement in the patient's voice. This is of course due to the circumstance that a fissured palate is not a mere slit or rent, but an absolute want of substance in the part, and that hence the approximation of the edges of the cleft converts the soft palate into a curtain, which is tightly stretched across the fauces, and which leaves a space behind, through which air enters the posterior nares and gives rise to the peculiar guttural sound of the voice so often observed in these cases.

In order to obviate this defect, Mr. Mason performs a supplementary operation three or four weeks after the successful closure of the palatal fissure:—

"A narrow spatula is first passed behind the soft palate, partly to steady it, and partly to draw it forward. A sharp-pointed bistoury is then made to transfix the soft palate at the inner edge of the hamular process, . . . first striking against and then being carried by the side of and beyond the spatula. An incision is made, . . . severing the attachments of the palate to the side of the fauces, together with the anterior and posterior pillars, dividing in its course chiefly the tensor palati, and palato-glossus, and palato-pharyngeus muscles. After the incision is completed, the palate retracts by muscular action. . . . The proceeding is repeated on the opposite side, and thus the palate is converted into a loose, movable curtain, somewhat resembling the uvula on a large scale, which in favourable cases effectually shuts off the communication between the posterior nares and the cavity of the mouth. Thus the passage of air is diminished, if not entirely prevented from passing upwards towards the nose during the act of speaking. The last step of the operation consists of introducing with a needle one or two stitches, from before backwards, through the sides of the flap, hemming the mucous membrane, as it were, . . . to prevent adhesion between the cut surfaces."

Mr. Mason has employed this operation in eleven cases, always with some, and often with very marked, benefit to the patient.

Art. XIX. *Contribution towards the Surgical Treatment of Diseased Joints.* By Sydney Jones, F.R.C.S., M.B., etc.—This paper may be regarded as a continuation of that published under the same title by the author, in the first volume of the Reports.[1] Five cases of excision are detailed, viz., four of the knee, and one (by Lister's method) of the wrist-joint. One of the knee cases terminated fatally, but the other three, and the case of wrist-joint excision, resulted in the preservation of very useful limbs. Mr. Jones promises to record, in the next volume of the Reports, a number of cases of excision occurring in young subjects. This interesting paper is illustrated with two excellent lithographic plates.

The volume terminates with the customary carefully compiled medical and surgical statistical tables, and with a short account of "The Old Students' Gift" to the hospital which gave them their education, this gift consisting in finely executed busts of one of the early surgeons and one of the early physicians of the hospital, the illustrious Cheselden, and the no less illustrious Mead. Excellent heliotypes of these busts accompany the volume, the portrait of Cheselden serving as a frontispiece, and that of Mead being inserted among the closing pages of the book.

In laying down the second volume of the new series of St. Thomas's Hospital Reports, we remark with pleasure that its list of contributors now embraces a very large proportion of the medical officers of the Hospital, there being indeed but two or three whose experience during the current year appears to have furnished nothing worthy of publication; on the other hand, there are fewer papers than in the first volume by gentlemen unconnected with St. Thomas's, so that the Reports are more closely approaching to what should be their distinctive character, as emanating from a Hospital Staff. J. A., Jr.

Art. XXV.—*Transactions of the Medical Society of the State of New York for the Year* 1870. 8vo. pp. 429. Albany, 1870.

This handsome volume contains, in addition to a record of the Society's proceedings at its sixty-third annual meeting, and the various lists of officers, honorary and permanent members, etc., several papers of more or less scientific interest, to the more important of which we now intend to invite our readers' attention.

The "President's Address," by James P. White, M.D., of Buffalo, has for its subject *Progress in Medicine*, and succinctly enumerates and comments upon some of the most noteworthy improvements in the healing art which have been introduced during the last forty years.

The next article is a "Case of luxation of the tendons of the posterior tibial and peroneal muscles of both legs, from stretching or rupture of the annular

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[1] See number of this Journal for April, 1871, p. 528.